

## **QUARTERLY REPORT**

### **HEALTH IMPROVEMENT DIRECTORATE**

#### **April 2009**

#### **Introduction**

This is the 4<sup>th</sup> board report for the year 2008/2009 produced by NHS Birmingham East and North (NHS BEN) Health Improvement Directorate. The report covers the period from January 2009 to April 2009 and will demonstrate the progress the Trust has made in response to local and national health improvement targets. It includes a detailed review of four of the key areas in which the Directorate is currently working. Each individual account will provide the board with a clear picture of current achievements, challenges and plans for the future. For the purpose of this report this paper will focus on the following areas,

- Social Marketing
- Infant Feeding
- Healthy Schools
- Falls Prevention and Bone Health

#### **Directorate Summary**

NHS BEN has responsibility to the health needs of a population of approximately 438,000. The Health Improvement Directorate oversees the major areas where health inequalities exist across our population. It has an important role in reducing those inequalities through the development and commissioning of services that will deliver high quality, cost effective and equitable health care. In order to achieve this, the Directorate has set four key principles upon which all its work is based,

- Prevention through commissioning
- Working in partnership
- Understanding our population
- Knowing what works

The following evidence describes how the Directorate contributes to these key principles through a variety of approaches that are both strategic and operational. The use of Social Marketing strategies for example, will highlight how the Directorate works closely towards building partnerships that shape services that appeal to high risk groups along with promoting the skills that lead to behaviour change. For this reason the PRIME project (Part 1) is crucial to both personal and behaviour lifestyle change and also the establishment of a workforce that will provide the support to help individuals to change their health behaviour.

The second part of this paper will discuss the promotion of breast feeding across Birmingham East & North. Breast feeding is a crucial component to reducing the inequalities that exist across Birmingham. The promotion of breast feeding has been identified as a key priority for the Government with all Trusts increasing the breast feeding initiation rate by 2% on a yearly basis.

NHS BEN is working consistently towards reaching this goal as one of its World Class Commissioning outcomes as identified in the Trusts three year strategic plan. There is a strong emphasis placed on the hardest to reach groups such as young mothers and women from routine and manual occupations. The success of the promotion of breast feeding initiation depends not only on understanding the population but also in identifying how we can work in partnership to commission services that will work for them.

Together, the promotion of breast feeding and healthy school programmes is critical to increasing the life expectancy of future generations across BEN. A healthy childhood begins in infancy and can continue across the life span if individuals are given the opportunities to do so. The National Healthy Schools Programme (NHSP) discussed in part three of this paper, underpins the idea that all pupils should be given the capacity to develop their life skills. Learning how to interact with others, recognise talents and staying healthy are a few of the key elements that the NHSP encompasses. The Health Improvement Directorate believes that in every area of health we are in a position to influence and create a healthy population, across all age groups for example in the prevention of falls in the elderly and across every social spectrum. NHS BEN believe that,

“Working in partnership to tackle inequalities and improve health and well-being”,

is the core purpose of everything we do. Being part of the NHSP, the promotion of breastfeeding, falls prevention and social marketing techniques are fundamental to achieving this goal.

## **1. Social Marketing**

This paper outlines current progress and future plans for the Social Marketing element of the PRIME programme. Overall activity at Programme level is outlined for information. Information about outcomes of individual projects is not discussed in this paper.

### **The PRIME programme**

Social Marketing activity forms part of the three year partnership between NHS Birmingham East and North and Dr Foster Intelligence (DFI) to deliver a Programme for Relationships, Intelligence, Metrics and Equality (PRIME).

The overall aims of the social marketing strategy are:

- To reduce the health inequalities within the PCTs population;
- To differentially drive behavioural change in those groups at highest risk;
- To design services attractive to key high risk groups;
- To build the knowledge and skills of the PCT's workforce; and
- To embed social marketing skills and approaches within PCT activities

## Overview of social marketing

Social marketing is defined as:

*“The deployment of patient focused, strategic planning and implementation to achieve specific behavioural goals within health improvement and patient care, delivered on a systematic and sustainable basis.”* National Social Marketing Centre

The Choosing Health (2004) White Paper highlighted social marketing as an important approach to encouraging positive behaviour change and recognised it as having the potential to enhance and make a significant contribution to both national and local health improvement work.

The process of social marketing involves using a range of intelligence to identify and target communities. Quantitative and qualitative approaches are then used to research their lifestyle and establish how best to communicate the benefits of a particular behaviour change. Following identification and understanding of target communities, services can then be designed or modified and campaigns delivered to assist behaviour change and the adoption of healthier lifestyles. All activities are evaluated and followed up to ensure effectiveness and share learning.

## Priority Areas for Tackling Inequalities

The priority areas for the PRIME programme have been identified as:

- Infant mortality
- Obesity
- Alcohol
- Smoking
- Mental health

The priority areas were identified following a base lining exercise to assess where activity should focus in order to make the most difference when reducing inequalities with the aim to improve the health and wellbeing of the population so that they will enjoy 10 more years of healthy life.

## Social Marketing Strategy: Draft 1

An initial draft of the Social Marketing Strategy was compiled in December 2008 to guide initial social marketing projects funded to take place from September 2008 to February 2009. The initial two social marketing projects were defined prior to the completion of the base lining exercise and focused on using social marketing methodology to:

- Maximise the number of people accessing drop in stop smoking services in Quarter 3 of 2008/09.
- Conduct primary research to influence the design and promotion of the NHS Health Check (Vascular Checks) pilot programme.

**Social Marketing Strategy: Draft 2**

The second draft of the Social Marketing Strategy will outline the areas for focus of Social Marketing activity for the remainder of three year PRIME programme in line with the priority areas outlined through the base lining exercise. Of these priority areas, a Social Marketing project to reduce smoking prevalence in identified communities is currently in progress.

**Reducing Smoking Prevalence**

The initial stages of the Social Marketing project to reduce smoking prevalence have been completed. Quantitative analysis has identified key populations for where activity should focus based on Mosaic™ lifestyle groups (see fig 1).

- There is significant disparity between the highest and lowest conversion rates for people from different Lifestyle Groups – 43% of people from Lifestyle Group C who contacted the Service went on to become four-week quitters, but only 32% of Lifestyle Group F.
- Increasing the conversion rates for all Lifestyle Groups so that they match the best conversion rate would clearly be an effective way of increasing quit rates. Any work on this should focus on the groups that provide most contacts.
- Lifestyle Groups D, G and H provide the highest number of contacts to the Service. However, conversion rates for Group G are significantly below average; for Groups D and H they are about average.
- These three Lifestyle Groups also have the largest total adult populations in the PCT area. They should therefore form the target audience for any interventions.
- In addition, Group F should be added to the target audience, because it shares enough characteristics with Groups D and G that interventions should be effective across all groups.

Figure 1: Mosaic Lifestyle groups identified for through quantitative analysis

Qualitative analysis has also been completed through focus group with members of the identified key populations. The comments and views expressed through the focus groups will influence interventions that will:

- Increase the effectiveness of the stop smoking service provided by NHS Birmingham East and North
- Consider alternative services for smokers who are never likely to use the current service provided by NHS Birmingham East and North

The next stage of the will consider proposals from Dr Foster on how NHS Birmingham East and North can reducing Smoking Prevalence project in the identified key populations.

### **Conclusion and Next Steps**

The first six months of the Social Marketing work programme has enabled NHS Birmingham East and North and Dr Foster to establish partnership relations, establish a Social Marketing Steering Group, use Social Marketing methodologies and develop a Social Marketing Strategy. The following two years and six months of the work programme will focus on developing Social Marketing projects to tackle inequalities in line with the priority areas outlined through the Base lining exercise.

## **2. Infant Feeding**

Breastfeeding has a major role to play in public health. There is clear evidence that breastfeeding has positive health outcomes for both mother and baby in the short and long term. Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months of an infants' life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, ideally into the second year, whilst gradually introducing a more varied diet (DH 2003). Babies who are not breastfed have an increased risk of:

- SIDS
- Type 1 and 2 diabetes
- Necrotising enterocolitis
- Protection for gastro-enteritis
- Acute otitis media
- Non-specific gastroenteritis
- Urinary tract infections
- Obesity
- Atopic disease
- Childhood leukaemia
- Severe lower respiratory tract conditions

Mothers who do not breastfeed have an increased risk:

- Breast and ovarian cancers
- Difficulty in returning to their pre-pregnancy weight.

In addition, the better health afforded by breastfeeding, can result in major financial saving for the NHS. Studies have also suggested that breastfeeding has positive effects on the wider economy and the environment.

Breastfeeding has been identified by the Government as a key strategy in tackling health inequalities (DH 1998; 1999; 2000; 2004a; 2004b). In 2003 a

breastfeeding initiation target was introduced by the Government for PCt's to deliver an increase of breastfeeding initiation by 2% year on year (DH 2003a). The target had a focus on increasing breastfeeding initiation amongst disadvantaged groups. This became a local target from April 2008. NHS Birmingham East and North Strategic Plan identifies breastfeeding as one its 10 World Class Commissioning health outcomes to increase breastfeeding initiation rates to 85% by 2018 to provide natural protection against illnesses and future obesity. In 2008 the Department of Health introduced a 6-8 week prevalence target (2008).

The UK Infant Feeding Survey 2005 found breastfeeding initiation rates in the UK to be amongst the lowest worldwide at 76%, 48% prevalence at 6 weeks and 25% at 6 months. The Survey also highlights inequalities in breastfeeding. Younger women and those who left school at 16 are less likely to breastfeed (51%) compared to older women who went onto further education (88%). Women from routine and manual groups are also least likely to breastfeed (65%) compared to professional groups (88%) (DH 2005). This report provides an update on progress and future plans to improve the uptake and duration of breastfeeding within NHS Birmingham East and North.

### **Breastfeeding Rates within NHS Birmingham East and North**

Breastfeeding rates within the Trust are below the national and West Midlands average, and parts of the Trust have very low uptake of breastfeeding.

#### **Breastfeeding Initiation Rates**

The mother is defined as having initiated breastfeeding if the baby is put to the breast or receives any of the mother's milk within the first 48 hours of birth.

Breastfeeding initiation data from the Local Delivery Plan Returns, demonstrates that breastfeeding initiation rates are below the national average. Data quality issues were identified in 05/06. The Health Improvement Department worked intensively with the two main maternity units, Heartlands Hospital (includes Solihull unit) and Good Hope Hospital during Q2 - Q4 06/07 to ensure robust data collection. This work resulted in a significant increase in data coverage and initiation rates enabling the PCT to meet the target for 06/07 and 07/08. In 2007 the West Midlands Perinatal Institute also began to collate data as part of the Reducing Perinatal Mortality Project.

However, the increase in breastfeeding initiation has not been sustained. Issues highlighted by the units, includes increase in birth rates, workforce capacity issues. Work is ongoing to address these issues.

NHS Birmingham East and North have been successful in a recent Department of Health inequalities funding bid for £95,532.00, to improve uptake and duration of breastfeeding. This funding will be used to support maternity units and the PCT's work to achieve full Unicef Baby Friendly

accreditation. The focus will be to ensure the maternity units make progress ahead of the PCT. In addition, this year, the Department of Health is providing each antenatal woman with a breastfeeding DVD which is available in different languages. The Health Improvement Department is also working with maternity services to ensure breastfeeding information is integrated within the 'Healthy Start' application process.

**Table 1- PCT LDPR Maternity Data 2006-2007**

<b>Breast Feeding Initiation Rates for 06/07</b>	Q1	Q2	Q3	Q4	YTD
% initiated B/Feeding 06/07 BHH	46%	51%	63%	63%	<b>56%</b>
% initiated B/Feeding 06/07 GHH	51%	54%	67%	66%	<b>62%</b>
LDPR 06/07	49%	53%	64%	64%	<b>59%</b>
<b>LDP Target</b>	<b>56%</b>	<b>57%</b>	<b>58%</b>	<b>58%</b>	<b>58%</b>

NB: from Q3 06/07 East and North PCT merged

**Table 2- PCT LDPR Maternity Data 2007-2008**

<b>Breast Feeding Initiation Rates for 07/08</b>	Q1	Q2	Q3	Q4	YTD
% initiated B/Feeding 07/08 (BHH & GHH)	60.12 %	60.94 %	60.27%	60.35 %	<b>60.42 %</b>
LDPR 07/08	61.06 %	61.73 %	59.53%	60.30 %	<b>60.39 %</b>
<b>LDP Target</b>	<b>58.00 %</b>	<b>58.00 %</b>	<b>59.00%</b>	<b>60.00 %</b>	<b>60.00 %</b>

**Table 3 – PCTI Maternity Data (formerly LDPR Data) 2008-2009**

	Q1	Q2	Q3	Q4	YTD
<b>Heartlands</b>	57.35%	55.07%	57.10%		
<b>Solihull</b>	56.35%	56.41%	59.67%		
<b>Good Hope</b>	65.52%	63.37%	63.91%		
% Initiated Data 08/09 BHH & GHH	60.38%	58.83%	60.18%		
%Initiation Data 08/09 PCT Maternities	60.71%	58.90%	60.43%		
<b>Target</b>	<b>62.00%</b>	<b>62.00%</b>	<b>62.00%</b>		

Tables 1 - 3 show breastfeeding initiation data from Local Delivery Plan Returns for the Trust. Table 1 demonstrates a significant increase in initiation rates following intensive work with maternity units. However, this increase has not been sustained as seen in Tables 2 -3.

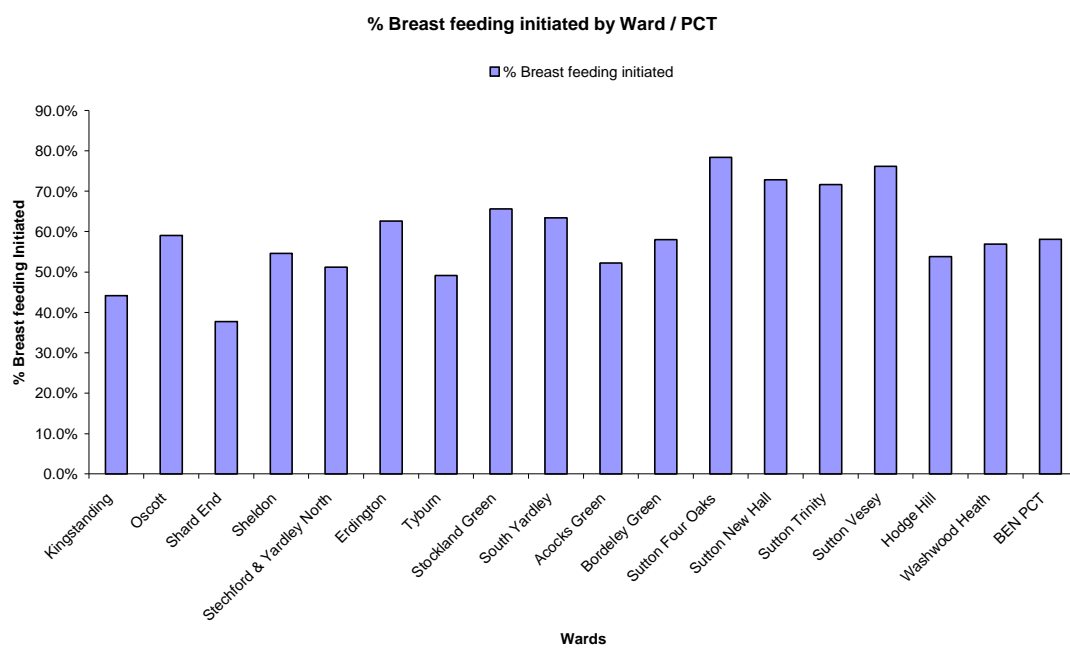
**Table 4 PCT Breastfeeding Initiation by locality 2007**

Ward / Locality	Total	Number	%
Kingstanding	351	155	44.2%
Oscott	264	156	59.1%
<b>Kingstanding Locality</b>	<b>615</b>	<b>311</b>	<b>50.6%</b>
Shard End	278	105	37.8%
Sheldon	97	53	54.6%
Stechford & Yardley North	287	147	51.2%
<b>3S Locality</b>	<b>662</b>	<b>305</b>	<b>46.1%</b>
Erdington	281	176	62.6%
Tyburn	352	173	49.1%
Stockland Green	305	200	65.6%
<b>BNE Locality</b>	<b>938</b>	<b>549</b>	<b>58.5%</b>
South Yardley	331	210	63.4%
Acocks Green	161	84	52.2%
Bordeley Green	690	400	58.0%
<b>BSA Locality</b>	<b>1182</b>	<b>694</b>	<b>58.7%</b>
Sutton Four Oaks	208	163	78.4%
Sutton New Hall	206	150	72.8%
Sutton Trinity	229	164	71.6%
Sutton Vesey	197	150	76.1%
<b>ASP Locality</b>	<b>840</b>	<b>627</b>	<b>74.6%</b>
Hodge Hill	355	191	53.8%
Washwood Heath	750	427	56.9%
<b>WWH Locality</b>	<b>1105</b>	<b>618</b>	<b>55.9%</b>
<b>BEN PCT</b>	<b>5342</b>	<b>3104</b>	<b>58.1%</b>

Source: West Midlands Perinatal Institute

Table 4 and Figure 1 – shows breastfeeding initiation rates by Ward and Locality. There is considerable variation in breastfeeding uptake between the Wards within NHS Birmingham East and North. Shard End and Kingstanding have the lowest uptake and they also have higher teenage pregnancy rates.

**Figure 1 – PCT Breastfeeding initiation 2007**

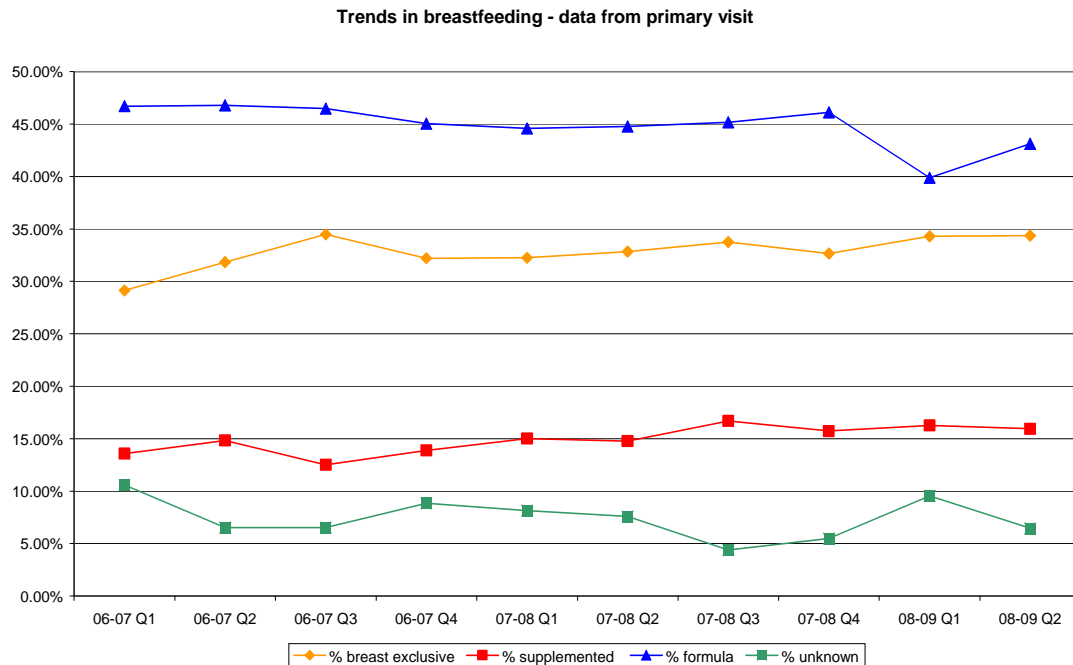


Source: West Midlands Perinatal Institute

**Breastfeeding Duration Rates**

Nationally, breastfeeding rates decline rapidly during the first two weeks and this is also reflected in the Trust data as demonstrated in Figure 2. Improving breastfeeding support during this critical period will be the focus of future investment.

**Figure 2 – Breastfeeding rates at 10-14days (first Health Visitor contact)**



Source: *BEN PCT Infant Feeding Audit*

**Breastfeeding Prevalence at 6-8 Weeks**

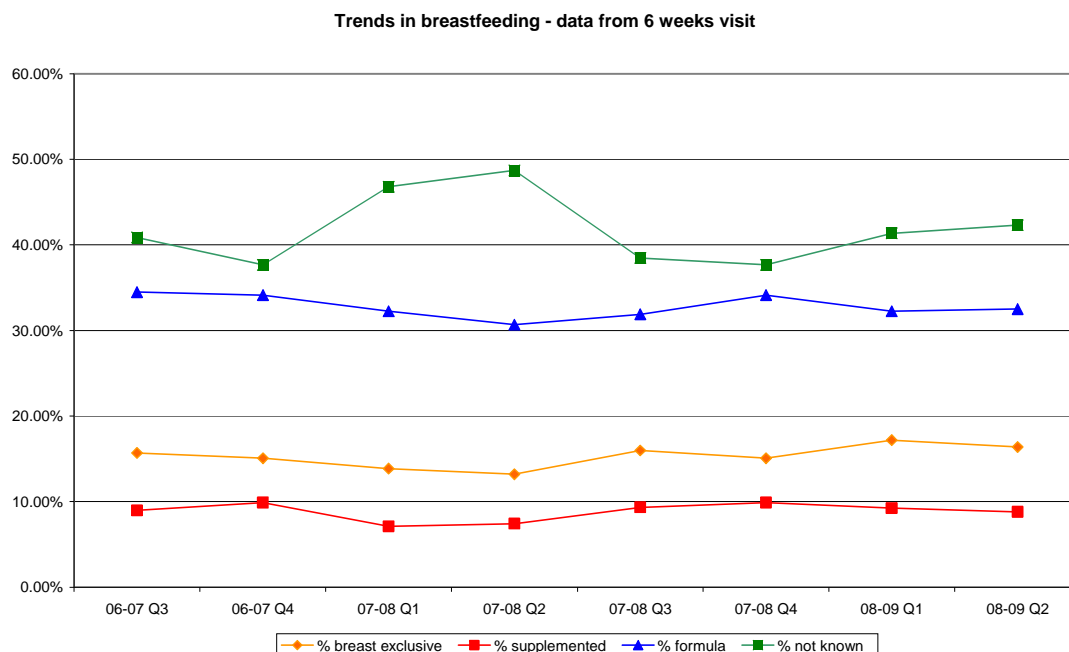
From April 2008, breastfeeding prevalence at 6-8 weeks became the Trust Vital Signs Target. Based on the Trust maternity data, targets have been set to increase data coverage as well as breastfeeding prevalence. The Department of Health Guidance stated that data should be collected at the infants' 6-8 week medical review using the Personal Child Health Records (red book). The main priority for this year was to improve data coverage.

The Trust's end of year target for calculated percentage of breastfeeding status recorded for all infants receiving a 6-8 week review is 85% and calculated prevalence of breastfeeding is 34.9%.

**Data collection**

The Trust was fortunate to have had baseline data for breastfeeding at 6 weeks because Health Visitors have been collecting data using the Infant Feeding Audit Tool at 10-14 days, 6 weeks and 6 months. Data is entered onto the Child Health System and quarterly reports are provided by Child Health. However, data collection at 6 weeks is still proving to be a challenge compounded by workforce capacity issues within the Health Visiting teams (Figure 2). The Health Improvement Department provides quarterly Audit reports to Health Visitor managers for performance management.

**Figure 2 – Trends in Breastfeeding Data at 6 weeks**



Source: BEN PCT Infant Feeding Audit

Considerable effort has been made by the Health Improvement Department to improve data collection using the Personal Child Health Records. The department has worked with Health Visitor and Clerical Worker Managers and developed a fail safe protocols for data collection. Health Visitor managers have been made aware of the high percentage of unknown data amongst some teams. Local breastfeeding data shows the Trust’s data coverage is higher compared to neighbouring PCT’s.

**Table 6 –Trust Data for Breastfeeding Prevalence at 6-8weeks Q1-3 2008-09**

Vital Signs Monitoring Returns Data	Q1 Actual	Q2 Actual	Q3 Actual	End of year target
Calculated percentage of status recorded	61.22%	74.13%	72.94%	85%
Calculated prevalence of breastfeeding	27.16%	25.81%	23.31%	34.9%

Table 6 shows the Trusts performance during Q1 - Q3 for the Vital Signs Monitoring Returns for breastfeeding status recorded and breastfeeding prevalence as a percentage of all infants receiving a 6-8 week review.

**Interventions to improve uptake and duration of breastfeeding**

**Unicef Baby Friendly Initiative (BFI)**

The Department of Health (DH 2008) and National Institute of Clinical Excellence (NICE 2005, 2006, 2008) recommends NHS Trusts adopt the Unicef BFI best practice standards. There is evidence that hospitals can increase their breastfeeding rates by 10% in a 4 year period when they achieve full Baby Friendly Accreditation (Unicef BFI 2000).

NHS Birmingham East and North are working towards full accreditation by implementing best practice standards jointly across maternity and Trust settings. Standards address:

- Policy
- Staff training
- Health education
- Practice issues

The department initiated the steering group which is overseeing the implementation of the Action Plan developed following the Action Planning visit by Baby Friendly in July 2008. The Department of Health funding will enable the Trust to pump prime this work to ensure maternity units and the NHS Birmingham East and North work to achieve full Baby Friendly accreditation. The focus will be to ensure the maternity units make progress ahead of the PCT.

**Table 7 – Local progress towards full Baby Friendly Accreditation**

Organisation	Registered	Certificate	Stage 1	Stage 2	Stage 3	Accreditation
NHS Birmingham East and North	X					
Heartlands & Solihull Maternity Unit	X	X	X			
Good Hope Hospital Maternity Unit	X	X	X			

Table 7 shows local progress amongst maternity units and NHS Birmingham East and North, towards achieving full Baby Friendly Accreditation as of 2008.

## **Breastfeeding Peer Counsellor Programme (Feeding Friends)**

Peer Support Programmes have been recommended as part of a breastfeeding strategy to improve breastfeeding rates (Birmingham City Council 2003, NICE 2005, 2006, 2008):

The pilot programme in Saltley/Alum Rock Washwood Heath/Bromford/Shard End, recruited 15 local mothers and 5 support workers who completed the training in December 2007. Unfortunately workforce capacity issues have impacted on the local co-ordination of this service. There are plans however, to complete this pilot with a view to rolling programme out to other targeted areas.

To compliment this work, salaried Breastfeeding Peer Supporter Workers will be recruited supported by the Department of Health funding. These workers will be based within the maternity units and targeted areas of the Trust to support mothers to initiate breastfeeding and support mothers to continue breastfeeding during the early postnatal period.

## **Social Marketing**

The department is working with the PRIME team to develop a social marketing campaign for Breastfeeding in 2009. In addition to this the department will be working with targeted schools to 'normalise' breastfeeding, influencing parents of the future.

## **Partnership Working**

The department is working with key partner agencies and seeking out new partnerships to develop support services for antenatal and postnatal mothers which are locally accessible and breastfeeding friendly. Breastfeeding resources have been circulated to each GP surgery and collaborative work in currently being undertaken with Children Centres to provide a breast pump loan scheme in each locality.

## **National Breastfeeding Awareness Week 10<sup>th</sup>-16<sup>th</sup> May**

The department has purchased an exhibition entitled 'Get Britain Breastfeeding' and accompanying interactive workbooks designed to raise awareness amongst young people. The Health Bus will take this exhibition on tour to targeted schools. The department is working with the communications team to attract local media attention.

The department will also be launching the recently updated Breastfeeding Policy and Guidelines for Food and Health.

## **Challenges for the Future**

There is considerable variation in breastfeeding initiation rates between the two maternity units which reflects the demographics of the population (table Table 4 and Figure 1) and reflects the findings from the 2005 Infant Feeding Survey.

It is important that an increase in breastfeeding initiation is sustained in order to meet the new Vital Signs Breastfeeding Prevalence Target.

Midwifery workforce capacity issues and increasing birth rates may impact on this work. Improved communication is required from relevant maternity leads to ensure active engagement in the future.

The priorities for the department in the coming year are as follows:

- Write a 5 year breastfeeding strategy
- Actively engage maternity providers and ensure recruitment of an Infant Feeding Co-ordinator at Heartlands Maternity unit.
- Build workforce capacity supported by Department of Health inequalities funding
- Engage with Commissioner for Maternity Services and Children and Young People
- Engage with provider arm to reduce the percentage of unknown breastfeeding data at 6-8 review
- Build social marketing and media campaigns to change public attitude to breastfeeding
- Submit NHS Birmingham East and North's application for the Baby Friendly Certificate of Commitment and work towards Stage1.

### **3. National Healthy Schools Programme**

The role of the National Healthy Schools Programme (NHSP) is to ensure that a minimum universal provision is in place to provide a framework within which schools can most effectively contribute to improving children's and young people's lives. This is measured through an agreed set of national outcomes. A healthy school is successful in helping pupils do their best and build on their achievements. It is a school which has created an enjoyable, safe and productive learning environment. The healthy school is committed to continuous development through self review and promotes an ethos of achievements; of valuing each member of the school community and supporting the development of all pupils to make the most of their gifts, talents and abilities. School is a key setting in which to improve both education and health. The National Healthy Schools Programme has been developed to facilitate this improvement.

A commitment to the National Healthy Schools programme features significantly in two major government strategies recently published; The Children's Plan: Building Brighter Futures (DCFS 2007) and Healthy Weight, Healthy Lives: A cross-government strategy for England (DH & DCFS 2008) which restate the National target for all schools to be engaged in their local programme by December 2009. The Children's Plan sites the programme as strengthening the vital role that schools play in promoting physical and mental health and emotional well-being and goes on to highlight the role of the programme in addressing personal development.

In Birmingham the NHSP is hosted by the Children, Young Peoples and Families Directorate, School Effectiveness Division, and is managed by the Health Education Service (HES) in partnership with each of the Birmingham Primary Care Trusts. Since its inception in 1999 the Healthy Schools Programme has been viewed as a change process to ensure that schools address physical and emotional health in their development plans and use a whole school approach to identify and address areas of need and priority. Since 2006, the formalisation of the programme into National Healthy Schools Status (NHSS) with its clear criteria for schools to be meeting targets across four themes, (PSHE education, healthy eating, physical activity and emotional health and well-being) support structure, self validation and quality assurance process, clearly defined what was expected from schools in order to improve children and young people's health.

### **The Local Picture**

Currently 98.6% of BEN schools are engaged in the NHS programme, with 75% having achieved NHSS. Barriers to engagement and progress include; schools placed in special measures or notice to improve by OFSTED, National Challenge Schools, sickness or absence (particularly senior management team) school staff recruitment or retention problems. Within BEN PCT the percentage of schools participating in the program has risen from just under 10% at the beginning of 2007 to the current 98.6%. The beginning of 2008 saw 49% of schools having achieved NHSS compared with 75% to date. With regards to the schools who haven't yet engaged, work is ongoing to support them into the process for when they are ready and to encourage existing health objectives.

Birmingham has an ambitious target of 100% of schools having gained NHSS by December 2009. This is sited within the current Council Plan. Within the BEN PCT area successful partnership working between the PCT Lead and the HES Adviser has been commended as an excellent model. Schools within BEN PCT generally follow the following process:

- Recruitment (an extra 39 schools were recruited between January 2008 and January 2009)
- A whole school staff meeting facilitated by the Healthy Schools Adviser and supported by the Healthy Schools Lead to undertake an audit of current practice against nationally agreed quality standards.
- Then in combination with the results of pupil and parent consultation, areas of development are identified and an action plan formulated to address the areas (usually over a 12 month period) ongoing support is offered by the Healthy Schools Adviser and Healthy Schools Lead as necessary.
- Schools re-do the consultation and derive quantitative and qualitative outcomes of the undertaken work.
- Schools reach a point of self validation in agreement with their Adviser and quality assurance partners.
- 10% of schools receive a moderation visit.
- Successfully meeting the quality standards qualifies schools to gain NHSS.

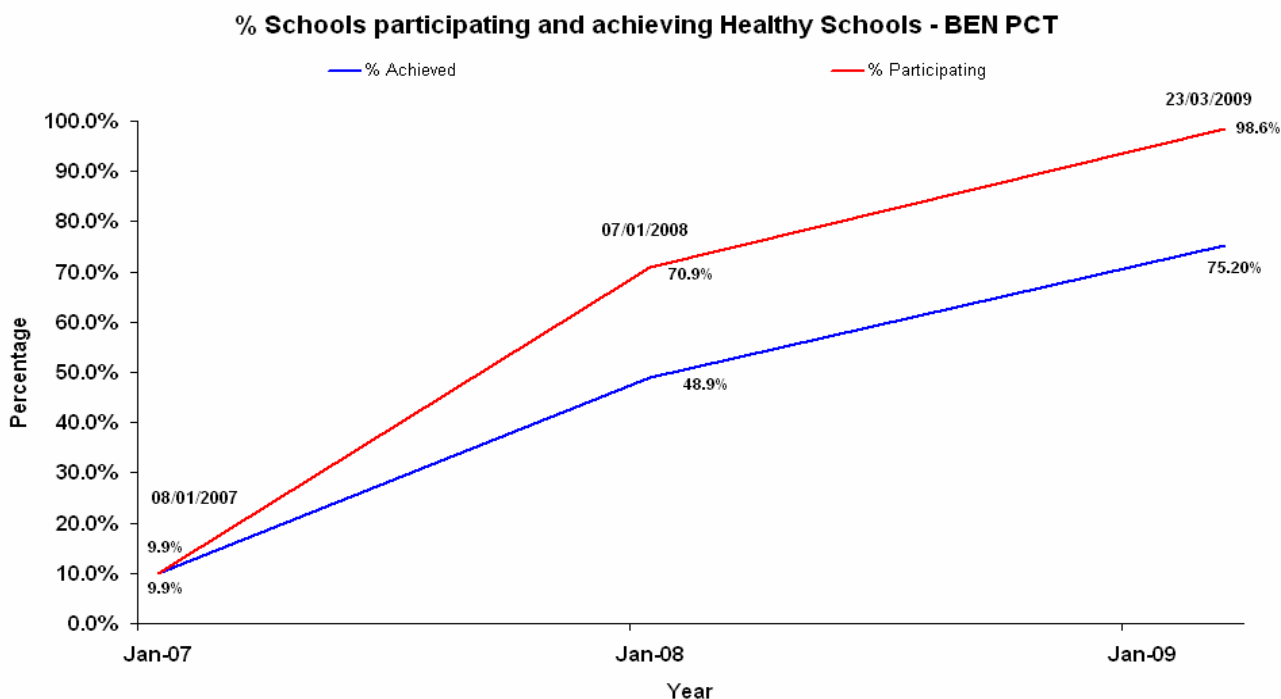
- Schools maintain the status for a three-year period during which they receive an annual review and target setting meeting from either the HES Adviser or PCT Healthy Schools Lead.

Within NHS BEN, the reviews are carried out by the PCT lead for schools within the following four extended schools cluster groups; Castle Vale, Clockwork (Oscott) Joined up (Perry Beeches) and Sutton East.

The aim of these visits is to ensure schools are better prepared for the renewal of their status but also to ensure that schools are building upon their initial achievements and broadening and deepening their work. The 2008 evaluation of the programme showed that within the four aspects of the programme all responding schools had either maintained their level of practice or had improved upon it. Some have made significant improvements particularly in the areas of pupil voice, increasing levels of pupils physical activity, increasing uptake of physical activity clubs, encouraging healthy eating and drinking habits, increasing uptake in healthier food options provided by the school and improving PSHE delivery throughout the school. The autumn 2008 evaluation of Birmingham Healthy Schools also asked schools about the effectiveness of these reviews and a hundred percent of schools that had received the meeting either agreed or strongly agreed with the statement "Through the annual review meeting the Healthy Schools consultant provides effective support for continuing development in Healthy Schools themes."

Scrutiny was made of all Birmingham schools who had received an OFSTED inspection between September 2007 and July 2008. The grades given for personal development of children and young people within schools were noted. Of the schools who have achieved NHSS 91% received either a good or outstanding within this area compared to 54% of schools who are not yet engaged in the programme. The Healthy Schools Program is only one of a number of processes which may have an impact on personal development but the data would suggest that it could be an influential factor.

**Chart 1 – Percentage and of number schools participating and achieving healthy school status – BEN PCT 2007 - 2009**



**Table 1 and 2 – Percentage and number of schools participating and achieving healthy school status – BEN PCT 2007 - 2009**

BEN PCT	Number of Schools		
08/01/2007	14	14	141
07/01/2008	69	100	141
23/03/2009	106	139	141

BEN PCT	% Achieved	% Participating
08/01/2007	9.9%	9.9%
07/01/2008	48.9%	70.9%
23/03/2009	75.20%	98.6%

**Current areas of work.**

National Childhood Measurement data helped to inform the selection of schools for a Theatre in Health and Education project (TIHE) entitled ‘Charlie and the kitchen Cook.’ 30 primary schools in the Kingstanding, Stockland Green and Washwood Heath areas were recruited to take part in the

programme which includes school staff training, resources, a whole school production by theatre company actors and follow-up support. Key messages include '5 a day', promotion of nutritionally balanced school meals and an awareness of the balance of good health guidance and messages. The Innovation and Good Practice award for BEN schools invited entries from schools, highlighting their good practice in terms of the work they do to promote the health of their school population. The categories of the schools were; Primary, Secondary and Special Schools. The assessment of the entries was made by the PCT Healthy Schools Lead and Health Education Service Adviser. The winning schools and runners-up are being presented with certificates at an awards ceremony being held at the banqueting suite of the Council House, Birmingham. Nicola Bengel, Director of Health Improvement will present the awards and give a congratulatory speech in recognition of the schools good practice.

Following observations from the HES Advisers, that the PSHE element of Healthy Schools can be particularly challenging for Secondary Schools, an enhancement program is being offered to five Secondary Schools in NHS BEN who are working towards NHSS. This program offers the school specialist training for staff who deliver PSHE education as well as specialist Adviser input to develop schools expertise around issues such as assessment and evaluation.

Training for school staff, Extended School Coordinators and School Nurses is provided on an ongoing basis. Termly network meetings are facilitated for NHS BEN primary schools in partnership with the HES. Meetings are themed around health improvement topics and allow time for sharing of good practice. Attendance at the meetings continues to grow with over a third of primary schools being represented. Work with other PCT professionals and services is ongoing, ensuring that schools are aware of and have routes for referral into services, as well as having up to date information that will benefit their school population. All NHS BEN schools received a copy of the 2007/2008 Public Health Report, allowing them access to health data, an overview of PCT priorities and ward based health statistics.

Strong links are maintained between our Healthy Schools Lead and Birmingham Youth Service. Currently three youth workers within the NHS BEN area are involved in the PSHE professional development pilot which, for the first time is open to non-teaching and non-nursing professionals.

### **The Future**

Future aspirations include investment in PSHE modelling for schools in readiness for 2010 when PSHE education will be compulsory. Quality PSHE education contributes to the targets around reducing teenage conceptions and obesity levels. Offering intensive support to some schools to enable them to progress may encourage the schools facing difficulties to develop and deepen their Healthy Schools work.

#### **4. Falls Prevention and Bone Health**

Falls are a major cause of preventable morbidity and mortality in older adults, and the risk of falling increases with age. A fall can be defined as “an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness” (NICE, 2004). 50% of falls are due to accidents or trips (Patel, 2009), and are therefore preventable.

In 2006, there were 4.7 million people in the UK aged 75 and over. The number is projected to increase to 5.5 million by 2016 and to 8.2 million by 2031, a rise of 76 per cent over twenty-five years (National Statistics, 2007). Based on the above projections NHS Birmingham East and North’s population >65 yrs. will rise from 32,144 (2006) to 37,608 (2016) and 56,091 (2031).

##### **Burden of Falls**

Within the UK 30% of over 65yrs will fall each year, rising to 50% of 85yr olds - DOH 2001. Within the Trust this equates to 19,278 and 4,479 falls respectively. The proportion of people in institutions who fall is higher than in the community. Of those who survive fractures represent a major threat to mobility and independent living - approximately 50% of hip fracture patients losing their ability to live independently.

Most falls do not result in serious injury but falls can destroy confidence, leading to increased social isolation, deterioration in mental health and erosion of independence. The after-effects of even a minor fall can be major, affecting an older person’s physical and mental health. Hypothermia is a significant risk as is pressure-related injury, especially when somebody who has fallen is unable to get up.

##### **Costs**

The cost of falls to the NHS and Personal Social Services was £908.9 million and 63% of these costs were incurred from falls in those aged 75 years and over (NICE, 2004). Hip fractures alone cost the NHS £1.7 billion/year and up to 14, 000 people a year die in the UK as a result of an osteoporotic hip fracture (NSF 2002).

**Cost of fractured neck of femur – 2007 - 08**

An estimated cost of neck of femur repair using an average of the non-elective tariff for this type of surgery:

**£5,016 x 298\* = £1, 494768**

Females account for 70% of this cost. The tariff excludes other costs e.g. rehab and long term care.

\* Neck of femur surgery, Secondary User Service (SUS)

**Risks**

Osteoporosis is a leading cause of falls fracture. It is a condition characterised by a reduction in bone mass and density increases the risk of fracture when an older person falls. In the UK, one in two women and one in five men over the age of 50 yrs. will break a bone mainly because of poor bone health, NOS, 2009. One in three women and one in twelve men over 50 yrs. are affected by osteoporosis and almost half of all women experience an osteoporotic fracture by the time they reach the age of 70 yrs., DH, 2001.

Other risk factors include: early menopause (before the age of 45), early hysterectomy (before the age of 45), long-term immobility, heavy drinking and smoking.

**Policy and Guidance**

The main policies and guidelines in relation to falls prevention are:

- Preventing Falls: Help the Aged Policy Statement, 2007
- A New Ambition for Old Age, DH 2006
- National Service Framework for Older People - Standard 6: Falls
- National Service Framework for Older People - Standard 8: The promotion of health and active life in older age
- National Institute of Clinical Excellence: Clinical Guideline 21 - The Assessment and Prevention of Falls in Older People

**Targets and Falls Prevention**

Falls Prevention (FP) does not appear in the Local Area Agreement. In terms of World Class Commissioning, FP can be included in two of the Outcomes: Health Inequalities and Life Expectancy. FP is performance managed by the SHA through the health inequalities performance report. It also appears in Local Strategic Partnership Community Strategy Delivery Plans, e.g. Sutton Coldfield, which has a focus on homes and residential settings. It is also an Objective in a number of LCDPs, e.g. BNE.

**Falls in NHS Birmingham East and North**

Unless otherwise stated all data is for the period 2007 – 08 (SUS).

The femur is the commonest of fragile bone fractures, and neck of femur injuries account for 80% of these fractures. Neck of femur accounted for 298 out of 367 diagnosed fractures of the femur within NHS Birmingham East and North, 2007 -08 (see table 1). 99% of admission types were non elective, and 90% of care was provided by Heart of England Foundation Trust.

Table 1: femur fractures

<b>Primary Diagnosis Description</b>	<b>Primary Diagnosis (ICD 10)</b>	<b>Total</b>
Fracture of neck of femur	<b>S720</b>	271
	<b>S7200</b>	27
<b>Fracture of neck of femur Total</b>		<b>298</b>
Pertrochanteric fracture	<b>S721</b>	44
	<b>S7210</b>	6
<b>Pertrochanteric fracture Total</b>		<b>50</b>
Fracture of femur, part unspecified	<b>S729</b>	5
	<b>S7290</b>	2
<b>Fracture of femur, part unspecified Total</b>		<b>7</b>
Fracture of lower end of femur	<b>S724</b>	4
	<b>S7240</b>	1
<b>Fracture of lower end of femur Total</b>		<b>5</b>
Fracture of shaft of femur	<b>S723</b>	5
<b>Fracture of shaft of femur Total</b>		<b>5</b>
Subtrochanteric fracture	<b>S722</b>	1
<b>Subtrochanteric fracture Total</b>		<b>1</b>
Fractures of other parts of femur	<b>S728</b>	1
<b>Fractures of other parts of femur Total</b>		<b>1</b>
<b>Grand Total</b>		<b>367</b>

<b>Locality</b>	<b>Number of admissions</b>	<b>%</b>
ASP	117	<b>32%</b>
BSA	69	<b>19%</b>
3S	65	<b>18%</b>
Kingstanding	55	<b>15%</b>
BNE	36	<b>10%</b>
WWH	18	<b>5%</b>
unknown	7	<b>2%</b>

Table 2: admissions by locality

Admissions by locality for fractured femur shows that the highest number are seen from ASP 117 (32%) where as Washwood Heath has far fewer at 18% as can be seen in Table 2. Much of this variation maybe accounted for by the age profile of those localities.

Most durations of stay are up to two weeks but there are a significant number greater than 50 days - see chart 1. No seasonal variation in admissions was discernable – see chart 2.

Duration of Stay - Fracture Neck Femur 2007/2008

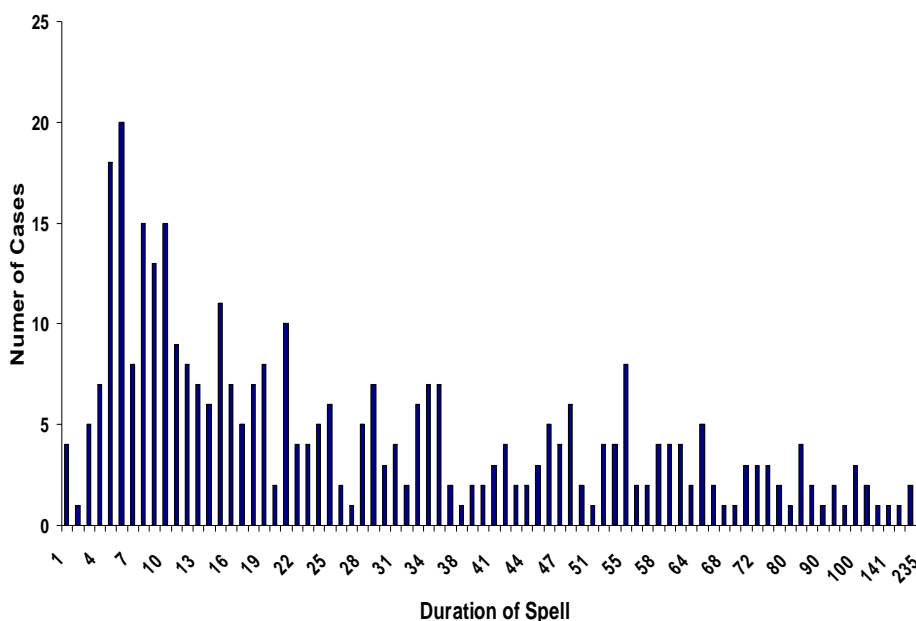
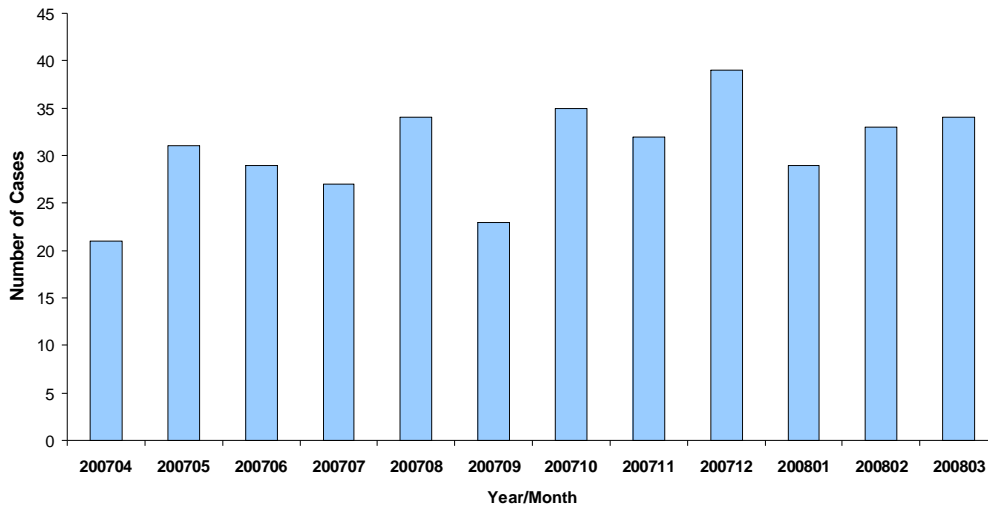


Chart 1: Duration of stay (days) – fracture neck of femur

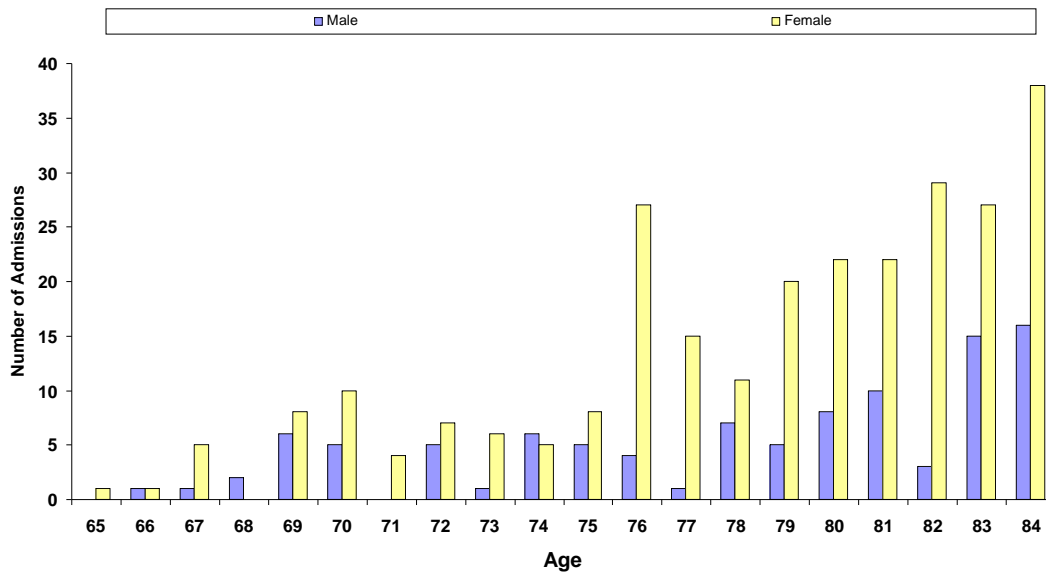
**Fracture Neck Femur admissions by Month - 2007/2008**



**Chart 2: Admissions by month**

The number of admissions in both males and females show a sharp increase after age 75 yrs – see chart 3. NHS Birmingham East and North has the highest Standard Mortality Ratio – Accidental Falls (all ages) compared to others in its ONS Cluster – see chart 4.

**Age / Sex Distribution of Fracture Neck Femur**



**Chart 3: Age, Sex and Distribution**

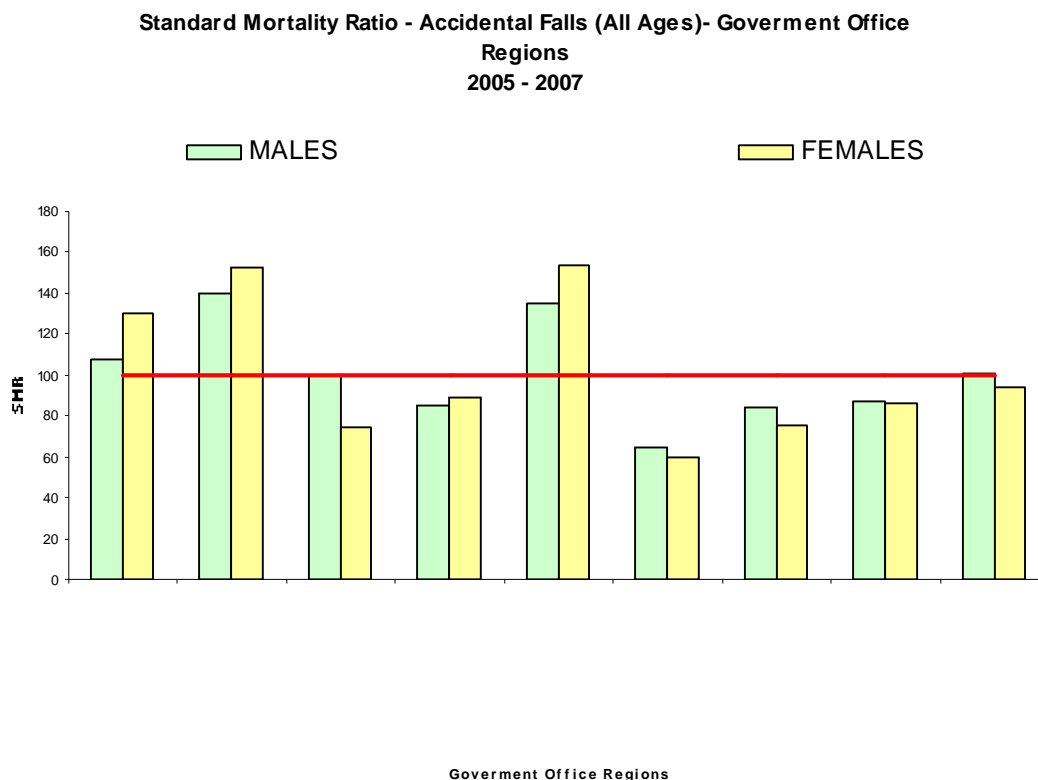


Chart 4: Standardise Mortality ratio – all ages: ONS cluster

**Current Activity**

NHS Birmingham East and North has its own Falls Prevention service with an establishment of 7 clinical staff plus administration support, which saw 475 patients during 2007 – 08. HoEFT has two consultant geriatricians with specialist responsibilities in this area.

FP appears in some LCDPs, which contain individual projects. For example, BNE recently conducted a projected in which 100 patients >65 yrs. were randomly sampled from GP lists. 30% were at high risk and not known to services. Locality commissioning intentions are under consideration.

**NICE Guidance**

There is no single approach to Falls Prevention (FP) that demonstrably reduces the risk of falling. NICE guidance (2004b) recommends a multifactorial approach should be adopted that identifies, assesses and addresses:

- muscle tone and balance
- falls history
- osteoporosis risk
- older person’s perceived functional ability and fear relating to falling
- degree of visual impairment
- degree of cognitive impairment and neurological examination

- degree of urinary incontinence
- home hazards
- cardiovascular examination and medication review
- NICE (DH 2004) recommends that everyone over the age of 65yrs should be routinely asked whether they have had a fall.

### **Future Actions to Support NICE Guidance**

A FP steering group has recently been convened and a set of actions were agreed:

- To investigate a city-wide strategic approach to FP, including strategy development, commissioning intentions and plans. NHS South Birmingham has, to date, expressed an interest in this. A response from HoBtPCT is awaited. Due to the nature of FP it cannot be addressed by NHS bodies alone, e.g. a large number of falls occur in residential accommodation, which has implications for BCC and the private sector.
- Local Implementation Group to oversee operational activity
- Health Needs Assessment
- To have an agreed and validated Risk Assessment Tool
- To establish an agreed clinical/care pathway
- Better screening/treatment of osteoporosis – a validated web based tool has recently become available. The Trust has a LES in place for osteoporosis screening.
- Fracture liaison service, which aims to reduce the risk of sufferers of minor fractures having further and more serious falls.
- Health Promotion activity to raise awareness of FP and risks
- A clear reporting structure to NHS Birmingham East and North's Board